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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/20/2011
FORM APPROVED
OMB NO. 0938-0391

45th 11/03/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445240	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/14/2011
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NAME OF PROVIDER OR SUPPLIER

LIFE CARE CENTER OF RED BANK

STREET ADDRESS, CITY, STATE, ZIP CODE

1020 RUNYAN DR
CHATTANOOGA, TN 37405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview the facility failed to maintain privacy for one resident (#22) of twenty-four residents reviewed.</p>	F 164	<p>This Plan of Correction constitutes our credible allegation of compliance. However, the submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal laws.</p> <p>F164</p> <p>1) The privacy for Resident #22 was maintained by the nurse after survey observation. This resident's roommate has dementia.</p> <p>2) The nursing management staff observed all other residents and discussed with nursing staff at time of survey to ensure privacy was maintained.</p> <p>3) The Staff Development Coordinator conducted an educational inservice on September 23, 2011 with the nursing staff regarding resident privacy, which included providing privacy for the resident when providing intravenous care and medication administration. An audit to ensure resident privacy will be completed by the Unit Coordinators or designee at least weekly for four weeks by then at least monthly for three months.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

OCT 03 2011

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F 164

Continued From page 1

The findings included:

Resident #22 was admitted to the facility June 13, 2011, with diagnoses including Post Surgery, Atrial Fibrillation, Osteoarthritis, Muscle Weakness, Dysphasia, and Diverticulitis.

Observation on September 14, 2011, at 10:30 a.m., in the resident's room, revealed registered nurse (RN) #1, changing the total parenteral nutrition (TPN) bag infusing via a central line catheter. Observation included RN# 1 exposing the resident's chest and abdomen. Further observation revealed RN #1 failed to pull the privacy curtain between resident #22 and the roommate.

Interview on September 14, 2011, at 10:40 a.m., outside the resident's room with RN #1, confirmed the privacy curtain was not pulled and the resident's roommate observed the procedure.

Review of the facility policy titled "Resident's Rights" revealed, "...a resident is treated with consideration, respect and full recognition of his/her dignity and individuality, including privacy in treatment and in care for his/he personal needs..."

Interview with the Staff Development Coordinator, on September 14, 2011, at 4:00 p.m., in the conference room, verified all employees are educated on providing and maintaining privacy during care giving and confirmed privacy should have been maintained with the administration of the TPN.

F 164

The audit results will be submitted to the Director of Nursing.

4) The Director of Nursing will submit the audit results to the Quality Assurance Committee monthly, consisting of the Medical Director, the Director of Nursing, and at least three other staff members for three months at which point the Quality Assurance Committee will determine the necessity for further monthly review. The administrator will monitor to assure continued compliance has been maintained.

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F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to follow the physician orders for a dressing change for one resident (#12) of twenty-four residents reviewed.</p> <p>The findings included:</p> <p>Medical record review revealed resident #12 was admitted to the facility on August 29, 2011, with diagnoses including Post Operative Infection, Removal of Cemented Hemiarthroplasty Complex, followed by Girdlestone Arthroplasty of the Left Hip.</p> <p>Medical record review of the Medical Director's NURSING HOME ADMISSION HISTORY & PHYSICAL completed August 30, 2011, revealed, "...2 different antibiotics to take. I notice that she did not tolerate the PICC (peripherally inserted central catheter) line last time in hospital. Hopefully will this time."</p> <p>Medical record review of the physician's orders revealed intravenous Vancomycin (antibiotic) continued to be administered through the intravenous PICC. Review of the physician's orders revealed, "Change PICC dressing weekly."</p> <p>Observation of the resident's PICC dressing on September 13, 2011, at 8:35 a.m., revealed the</p>	F 281	<p>F281</p> <p>1) The dressing change for Resident # 12 was changed by the charge nurse during the survey.</p> <p>2) Other residents with intravenous catheters were reviewed by the Unit Coordinator and Weekend Supervisor on September 13, 2011 to assure that all peripherally inserted central catheter (PICC) dressings were being changed according to physician's orders.</p> <p>3) The Staff Development Coordinator completed an educational inservice on September 23, 2011 with the licensed nursing staff regarding the facility's policy of changing peripherally inserted central catheter (PICC) dressings. An audit will be completed by the nursing management staff at least weekly for four weeks, then at least monthly for three months. Audit results will be submitted to the Director of Nursing.</p> <p>4) The Director of Nursing will submit the audit results to the Quality Assurance Committee, consisting of the Medical Director, the Director of Nursing, and at least three other staff members, monthly for three months at which point the Quality Assurance Committee will determine the necessity for further monthly review. The administrator will</p>		

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F 281	Continued From page 3 dressing was not dated to reflect being changed. Interview with the Registered Nurse Unit Coordinator at the West nursing desk on September 13, 2011, at 9:40 a.m., verified the dressing change order was on the Medication Administration Record. Interview confirmed the PICC dressing had not been changed by the nursing staff from admission, sixteen days prior, to the present; nine days after the date the dressing was due to be changed.	F 281	monitor to assure continued compliance has been maintained.		9/14/11
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure nutritional adequacy for the mechanically altered diet (puree) for twenty-two of one hundred twenty-seven residents. The findings included:	F 363	F-363 1) Cook #2 was immediately instructed to adhere to the specific recipe when preparing pureed meals. 2) The Certified Dietary Manager reviewed the puree recipes and observed for the remainder of the week on September 13, 2011 to assure placement of the recipes in the menu book for the dietary staff to follow		

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F 363	<p>Continued From page 4</p> <p>Observation on September 13, 2011, at 1:20 p.m., revealed the cook (Cook #2) was preparing to mechanically alter the food to puree form. Continued observation revealed Cook #2 removed a pan from the oven. Interview with Cook #2 during the observation, revealed the pan contained chicken and "other things" which had been cooking together. Observation and interview revealed Cook #2 poured the contents of the pan into the mixer and identified the contents as they were poured into the mixer. Cook #2 stated the contents were, "...2-3 cups of chicken, one large can of Cream of Mushroom soup, 2 scoops of mashed potatoes, and enough water to make it soupy." Observation continued and Cook #2 turned on the mixer, watched briefly, obtained tap water in a pan, and poured the unmeasured water into the mixer. During observation and interview Cook #2, when asked how much water is added, stated, "I only add water when the mixer starts shaking...add just enough to stop the shaking."</p> <p>Review of the facility recipe for BBQ Chicken revealed for a portion of 25 servings, 2 ounces of chicken is required. (The recipe required 2 ounces per 25 servings which equals 50 ounces or 6.25 cups of chicken. The facility was preparing 22 servings which required 5.5 cups of chicken.)</p> <p>Interview with Cook #2 in the kitchen on September 13, 2011, at 1:48 p.m., confirmed there is no recipe followed for the puree process, "I have made my own concoction so the residents like it."</p>	F 363	<p>3) The Dietary Manager conducted an educational inservice on September 22, 2011 with the dietary staff to ensure that puree recipes are being followed. Puree recipes/menu's are being placed into the menu book by the Dietary Manager each week. The Certified Dietary Manager and Dietary Manager will complete an audit weekly for four weeks, then monthly for three months to ensure compliance is maintained. Audit results will be submitted to the Director of Nursing.</p> <p>4) The Director of Nursing will submit the audit results to the Quality Assurance Committee, consisting of the Medical Director, the Director of Nursing, and at least three other staff members, monthly for three months at which point the Quality Assurance Committee will determine the necessity for further monthly review. The administrator will monitor to assure continued compliance has been maintained.</p>	10/11/11	

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F 363	Continued From page 5 Interview with the CDM (Certified Dietary Manager) on September 14, 2011, at the nurses' station at 9:50 a.m., confirmed the facility failed to ensure nutritional adequacy for the mechanically altered diet. Residents with triggered weight-loss were identified and reviewed; there was no identified relationship of weight-loss to the puree process.	F 363			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431	F-431 1) The expired flu vaccines and solutions were immediately destroyed by the Unit Coordinator during the survey. 2) The Nursing Management staff and some of the survey team assessed all other medications in the center on September 14, 2011 to ensure that there were no expired medicines. 3) The Staff Development Coordinator conducted an educational inservice on September 23, 2011 with the licensed nursing staff to ensure checking expiration dates prior to medication administration. An audit to ensure continued compliance will be completed by nursing management weekly for four weeks, then monthly for three months.		

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F 431	<p>Continued From page 6</p> <p>Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's product information, and interview, the facility failed to ensure Influenza vaccine in one of two medicine room refrigerators had not expired; and failed to ensure glucometer quality control solution had not expired on one of six medicine carts.</p> <p>The findings included:</p> <p>Observation on September 14, 2011, at 10:30 a.m., in the North East wing medication room, revealed five full vials of influenza vaccine with an expiration date of February 2011, in the medication refrigerator.</p> <p>Interview with the Staff Development Coordinator, on September 14, 2011, at 11:15 a.m., in the medication room on North East wing, confirmed the medication refrigerator contained five vials of Influenza vaccine with an expiration date of February, 2011.</p> <p>Observation on September 13, 2011, at 4:25</p>	F 431	<p>Audit results will be submitted to the Director of Nursing.</p> <p>4) The Director of Nursing will submit the audit results to the Quality Assurance Committee, consisting of the Medical Director, the Director of Nursing, and at least three other staff members, monthly for three months at which point the Quality Assurance Committee will determine the necessity for further monthly review. The administrator will monitor to assure continued compliance has been maintained.</p>	10/3/11	

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F 431	Continued From page 7 p.m., of the medicine cart in use on the 100 North hall, with registered nurse (RN) #2 revealed the glucometer quality control solution box open with two bottles inside. The bottles were labeled as being opened on June 10, 2011. Review of the manufacturer's product information insert for the quality control solution revealed, "...Precautions and Warnings: Do not use control solutions 90 days after opening..." Interview with the Patient Services Coordinator on September 13, 2011, at 4:45 p.m., at the medicine cart in use on the 100 North hall, confirmed the glucometer quality control solutions had expired.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441	F-441 1) The TPN tubing for Resident # 22 was placed in the correct position by the charge nurse. The Unit Coordinator labeled the bedpan for Resident # 10 at the time of notification during survey. 2) The Nursing Management staff assessed all resident bedpans in the facility on September 12, 2011 to ensure that all bedpans were all labeled.		

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F 441	<p>Continued From page 8</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview the facility failed to maintain aseptic technique during an intravenous infusion bag change for one resident (#22); and failed to ensure a bedpan was not used by more than one resident (#10) for twenty-four residents reviewed.</p> <p>The findings included:</p> <p>Observation during the initial tour of the facility on September 12, 2011, at 10:35 a.m., revealed a bathroom between two resident rooms contained three bedpans. The bedpans were in clear plastic bags. One bag contained a pink fracture (wedge) bedpan, unlabeled. The other bag contained two pink bedpans, one regular and one</p>	F 441	<p>3) The Staff Development Coordinator conducted an educational inservice on September, 23 2011 with the nursing staff regarding the labeling of bedpans. The Staff Development Coordinator conducted an educational inservice on September, 23 2011 with the nursing staff regarding proper aseptic technique. An audit to ensure compliance will be completed at least weekly for four weeks, then monthly for three months by the nursing management staff. Audit results will be submitted to the Director of Nursing.</p> <p>4) The Director of Nursing will submit the audit results to the Quality Assurance Committee, consisting of the Medical Director, the Director of Nursing, and at least three other staff members, monthly for three months at which point the Quality Assurance Committee will determine the necessity for further monthly review. The administrator will monitor to assure continued compliance has been maintained.</p>		10/11/11

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F 441	<p>Continued From page 9</p> <p>fracture bedpan, unlabeled. The bags were tied to the towel rail on the wall of the bathroom.</p> <p>Interview with licensce practical nurse (LPN) #1 on September 12, 2011, at 10:50 a.m., in the 100 hall nurse's station, confirmed all bedpans were to be labeled. Continued interview with LPN #1, in the resident bathroom containing the three bedpans, confirmed none of the bedpans were labeled and were used by the two residents of one room. Further interview with LPN #1 confirmed the facility was unable to ensure the single resident use of each bedpan.</p> <p>Interview with the Patient Services Coordinator on September 12, 2011, at 2:30 p.m., in the conference room, confirmed the facility practice was to label all bedpans.</p> <p>Resident #22 was admitted to the facility on June 13, 2011 with diagnoses including Post Surgery, Atrial Fibrillation, Osteoarthritis, Muscle Weakness, Dysphasia, and Diverticulitis.</p> <p>Observation on September 14, 2011, at 10:30 a.m., in the resident's room, revealed registered nurse (RN) #1 changing total parenteral nutrition(TPN) bag infusing via a central line catheter. RN #1 placed the bag on the bedside table, spiked the bag with new TPN intravenous (IV) tubing, and initiated priming of the tubing. While priming, RN #1 held the distal end of the tubing, allowing the tubing to lay on the floor. RN#1 completed the priming process, hung the TPN bag, and started the infusion.</p> <p>Review of facility policy titled "TPN/PPN Administration", dated June 29, 2007, revealed,</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF RED BANK			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 RUNYAN DR CHATTANOOGA, TN 37405		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 10 "...Licensed nurses caring for residents receiving infusion therapies are expected to follow infection control and safety compliance procedures..." Interview with RN #1, on September 14, 2011, at 10:40 a.m., outside the resident's room, confirmed the IV tubing was lying on the floor during the priming of the tubing.	F 441			

OCT 03 2011